



HEALTH QUESTIONNAIRE

Patient Identification Label

Height: _____ Weight: _____

Reason for Visit: _____

List ALL Medications you are taking, including over-the-counter medications, vitamins and herbal remedies:

List any ALLERGIES to medications: _____ No Known Allergies

SURGICAL HISTORY:

Please list all surgeries and appropriate year performed: _____

Do you have a personal history of cancer? No Yes If yes, location/type? _____

FAMILY CANCER HISTORY:

Indicate type and family member if known and age diagnosed:

Type, Relative, Age: _____ Type, Relative, Age: _____

Type, Relative, Age: _____ Type, Relative, Age: _____

SOCIAL HISTORY:

Do you drink alcohol? Never Rarely Moderate Daily type/amount per week _____

Do you use tobacco? Never Previously, but Quit Currently packs per day _____

Use of illegal/street drugs? Never Currently type/frequency _____

REVIEW OF SYSTEMS: Do you now or have you ever had problems related to the following? Circle Y or N

CONSTITUTIONAL

Fever Y N
Chills Y N
Nightsweats Y N

EYES

Visual changes Y N
Glaucoma Y N

ENT

Loss of Hearing Y N
Sinus/Allergies Y N

CARDIOVASCULAR

Heart Attack Y N
Angina/Chest Pain Y N
Heart Failure Y N
Heart Murmur Y N
Mitral Valve Prolapse Y N
Atrial Fibrillation Y N
High Blood Pressure Y N
Stroke/TIA Y N
Aneurysm Y N
Raynaud's Disease Y N

ENDOCRINE

Diabetes Y N
Thyroid Problems Y N
Gout Y N

RESPIRATORY

Pneumonia Y N
Asthma Y N
Emphysema Y N
Tuberculosis Y N

GASTROINTESTINAL

Abdominal Pain Y N
Indigestion Y N
Stomach Ulcers Y N
Hepatitis Y N
Irritable Bowel Y N
Blood in Stool Y N

HEMATOLOGICAL/LYMPH

Anemia Y N
Sickle Cell Y N
Blood Clots Y N
AIDS/HIV Y N
Enlarged Lymph Node Y N
Lupus Y N

GENITOURINARY

Bladder Infections Y N
Kidney Stones Y N
Kidney Failure Y N

MUSCULOSKELETAL

Back Pain Y N
Osteoporosis Y N
Arthritis Y N

INTEGUMENT/BREAST

Skin Rash Y N
Non-healing Sore Y N
Breast Lump Y N
Breast Lump Y N

NEUROLOGICAL

Dizzy Spells Y N
Seizures Y N
Headaches Y N
Multiple Sclerosis Y N
Head Injury Y N

Additional Medical Illness:

Provider Notes

Patient Signature: _____ Date: _____ Time: _____

Clinician Signature: _____ Date: _____ Time: _____

Surgical Options

- Lumpectomy
 Mastectomy

DO NOT WRITE BELOW THIS LINE

